

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

9421

2904

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4919 Maffit Pl.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 1yr.
 years, months or days)

8. (a) PRINT
FULL NAME

Mary E. Ryan

8. (b) If veteran,
name war

Nil

3. (c) Social Security
No.

Nil

4. Sex Female5. Color or
race White6. (a) Single, widowed, married,
divorced Widowed6. (b) Name of husband or wife
John J6. (c) Age of husband or wife if
alive Deed years7. Birth date of deceased July
(Month)14th. 1872
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

67

8

14

hr.

min.

9. Birthplace

(City, town, or county)

Austria

(State or foreign country)

10. Usual occupation

At Home

11. Industry or business

MOTHER FATHER

12. Name Unknown Mother13. Birthplace
(City, town, or county)Austria

(State or foreign country)

14. Maiden name Unknown15. Birthplace
(City, town, or county)Austria

(State or foreign country)

16. (a) Informant's own signature Mrs Eugene Kohler(b) Address 4919 Maffit Pl.17. (a) Removal (b) Date thereof 3/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Washington D.C.18. (a) Signature of funeral director Harrigan & Sheehan Und(b) Address 4415 Washington Blvd.19. (a) MAR 28 1940
(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Washington D.C. County _____
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Town Limits.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 60 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
 year 1940 hour 11:00 minute 40 A.M.

21. I hereby certify that I attended the deceased from May
39 to March 28, 1940
 that I last saw him alive on March 28, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary Edema
CarcinomatousDue to Carcinoma of bladderUrinary
53

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Carcinoma of Bladder

Of autopsy

Duration

2 days6 hrs11 mos.

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

C. While at work

(Specify type of place)

(a) Means of injury

23. Signature Eugene Kohler (M. D. or other) MD
4919 Maffit Pl.
 Address _____ Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3882

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.